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ADAPTIVE CLINICAL TEACHING

COLLEEN F. SHANAHAN AND EMILY A. BENFER*

Teaching is an exercise in adaptation and clinical legal teaching is no exception. Clinical teachers develop effective approaches through instinct, training, pedagogy, skill, and trial and error. Building on the trials, errors, and instincts of clinical teachers, this article offers a more intentional approach: “adaptive clinical teaching” (ACT). ACT is a structured method of guided analysis and reflection that applies to any clinical teaching situation, allowing a clinician to make her teaching choices based on as much knowledge and with as much intentionality as possible. ACT provides clinicians with an approach for new issues as they arise and builds a base of knowledge so that each clinical choice is not experienced anew. This article offers clinicians—and ultimately all legal educators—a systematic framework to apply ACT to their own teaching and an example of the application of ACT to demonstrate how the method encourages replacing instinct with deliberate strategies for teaching and supervising. It is the authors’ hope that clinical teachers will use the ACT model to create collections of knowledge for themselves and their colleagues, to challenge and broaden their teaching instincts, and to maximize learning for clinic students. These insights and the collected knowledge that results can also translate to legal education more broadly.

I. INTRODUCTION

Clinical teaching is an intensive process of design, classroom teaching, supervision, collaboration, and feedback. It also requires working with diverse generations, races, genders, political affiliations, learning styles, and personalities. As a result, the quality of a clinic directly relates to a clinical teacher’s ability to thoughtfully observe

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situations that arise and adapt her teaching strategies accordingly. As clinical teachers, the authors noticed recurrent supervisory and teaching situations in our clinics that traditional strategies and our own initial instincts did not successfully address. In these situations, we often learned that we did not fully understand all of the factors creating the situation and thus our natural instincts or assumptions failed us. As we grappled with how to handle these situations to yield productive learning for our students, we recognized the need for a systematic approach to planning and strategic thinking and began to examine and describe the methods that led us to successful clinical teaching experiences. This article describes “adaptive clinical teaching” (ACT), the system that resulted from this effort.

ACT asks the clinical teacher to engage in six steps, abbreviated as “ADAPTS”: 1) articulate the situation, 2) define the expectations, 3) analyze the contributing factors, 4) ponder potential strategies, 5) take action, 6) shape future choices through reflection. This framework allows for structured reflection in which the dynamics of clinical teaching are observed, analyzed and revised. The model provides a structure that allows the clinical teacher to examine the many contexts in which the teaching of skill development and personal evolution take place. In bringing clarity to the confounding factors in our clinics, the ACT method allows clinicians to be more deliberate and successful in developing and implementing solutions and strategies. Thus, ACT can serve as a model for new clinicians to develop their teaching skills, and as a framework for experienced clinicians to refine and reflect on their teaching.

ACT is not the only structured approach to teaching and supervising students. The method reflects the influence of scholars in psychology, sociology, adult learning, legal education, and clinical pedagogy.¹ Thus, the authors are not designing ACT from whole cloth, but rather aim to describe the process that many clinical teachers already implicitly or explicitly use to teach a variety of students in different clinical settings. Naming and structuring these steps turns instinct into intentional process. This article describes how the method encompasses the wisdom of many teachers and scholars, creates language and mechanisms to facilitate use of the method, and suggests that clinical teachers can use ACT to make intentional choices in the myriad situations presented to them. To illustrate how ACT can broaden the reflection and deepen the analysis that occurs in clinical teaching, this article applies ACT to an example supervision situation. It is the goal of this article to provide the ACT method as a

¹ See, e.g., *infra* note 2.

structured intellectual framework for deliberate and effective clinical teaching, and to begin the intentional development of a body of knowledge and strategies that emerge from the use of ACT.

II. THE ADAPTIVE CLINICAL TEACHING (ACT) FRAMEWORK

The ACT model builds on the rich literature on adaptive supervision and teaching that exists in multiple disciplines, including social work, medicine, psychology, and teacher education.² In the context of clinical legal education, the “adaptive supervision” concept was developed by Robert Stumberg for the Elements of Clinical Pedagogy Class at Georgetown University Law Center.³ In each discipline, there is a deceptively simple insight that is also at the core of ACT: a structured intellectual framework enables more intentional and effective clinical teaching.⁴ The theory rests on the premise that “an adaptive challenge is a particular kind of problem where the gap cannot be closed by the current technical know-how or routine behavior.”⁵

² For example, the “Adaptive Supervision in Counselor Training” theory of training psychologists relies on a “match and move” concept where supervisors “match their methods/interventions to supervisee readiness on a specific issue or cluster of issues and move that supervisee to increased readiness to address those issues in the future.” Robert A. Rando, *Adaptive Supervision in Counselor Training*, COUNSELING CENTER VILLAGE (June 7, 2012), <http://www.ccvillage.buffalo.edu/Villate/ElecProj/Rando.htm>. In the social work setting, the “Adaptive Supervision” model considers the supervisee’s needs and enables supervisor choices regarding how to balance “instrumental” behavior – a supervisor’s focus on skills, knowledge and resources – with “expressive” behavior – a supervisor’s focus on motivation, communication, and addressing stress. Jean E. Latting, *Adaptive Supervision: A Theoretical Model for Social Work*, ADMINISTRATION IN SOCIAL WORK (1986). The social work model of adaptive supervision parallels the clinical teaching scholarship, describing a continuum of behavior for supervisors, ranging from proactive – coaching, providing theory, and directing the worker towards other sources of information – to reflective – becoming a sounding board, helping the worker understand the foundation of his or her assumptions and actions. *Id.*

³ The adaptive supervision class began with the objective of providing new clinical teachers with a structured way of thinking about “difficult” supervision scenarios. As it evolved, the class became an effort “to create a more systematic approach for discovering the source of the unproductive work and for choosing appropriate solutions and interventions.” A particular insight of Stumberg’s work, embodied in the adaptive supervision class, is the approach of creating a chart that allows the teacher to structure her thinking about supervision. See Wallace J. Mlyniec, *Where to Begin? Training New Teachers in the Art of Clinical Pedagogy*, 18 CLINICAL L. REV. 505, 530-31 (2012) (describing this component of the training and its history, including Stumberg’s system guide at Appendix B); Robert Stumberg, *Notes on Dealing with Difficult Supervision* (Feb. 17, 2011) (on file with authors).

⁴ David Berliner, *Describing the Behavior and Documenting the Accomplishments of Expert Teachers*, 24 BULLETIN OF SCIENCE TECHNOLOGY & SOCIETY 208 (2004) (discussing expert teachers and explaining, “When anomalies occur, when things do not work out as planned, or when something atypical is noted, deliberate analytic processes are brought to bear on the situation”).

⁵ David Hirsh, *On the Origin of a Thesis: Medical Education as an Adaptive Practice*, 8 THE CLINICAL TEACHER 282, 284 (2011).

Thus, “[t]he word ‘adaptive’ also reminds the teacher that one form of intervention seldom can solve all of the difficult supervision issues that arise.”⁶ ACT embodies this view. It allows a clinical teacher to use an adaptive approach to address a variety of challenging situations. We begin by describing the underlying framework and guiding principles, and then provide a detailed examination of the six steps of ACT.

A. Guiding Principles

ACT rests on four core principles.

First, everything the clinical teacher does is a choice among options.⁷ These choices are ideally “intentional [and] further a student’s education.”⁸ Many clinical teachers aspire to an intentional approach to education, but whether a clinical teacher achieves this aspiration is often the result of instinct, intuition, skill, luck, or the time available. A recurring theme of the scholarship of clinical pedagogy is trying to understand the choices clinical teachers make and the resulting outcomes.⁹ Discussions about clinical supervision reflect the view that “often the [strained supervisory] relationship is the failure of the supervisor to recognize that the parties’ roles and dynamics change throughout the learning process and that supervising methods, teach-

⁶ Mlyniec, *supra* note 3. This concept is not unique to the law or to teaching. See, e.g., Linda M. Collins, Susan A. Murphy, Karen L. Bierman, *A Conceptual Framework for Adaptive Prevention*, PREVENTION SCIENCE 6 (2003) (stating that individuals in clinical trials may need adaptive intervention rather than fixed intervention, and it must be based on certain tailoring variables); Ajay K. Kohli, *Effects of Supervisory Behavior: The Role of Individual Differences among Salespeople*, 53 J. OF MARKETING 40, 49 (1989) (describing how sales managers should supervise their salesmen by changing their strategy based on the age and experience of the worker).

⁷ Brook K. Baker, *Learning to Fish, Fishing to Learn: Guided Participation in the Interpersonal Ecology of Practice*, 6 CLINICAL L. REV. 1, 55-56 (1999) (“When is supervision most helpful? Just as there are questions about the appropriate forms of workplace supervision, there are questions about its appropriate timing. Should supervision be focused on the planning stage to maximize the potential of student success in her initial performances? Or, as I have previously suggested about cognition/reflection itself, should supervision be primarily in-action, side-by-side with the student, in the trenches of the immediate dilemma? Conversely, is the most propitious time of supervision after-the-fact when the supervisor can engage the student in a learning mode dialogue and explore the contradictions of actual performance at a more leisurely pace? Life is short, time is at a premium, and multiple people may lay claim to the attention of supervisors. When, then, are the optimal times for devoting scarce supervisory resources to the student?”).

⁸ Mlyniec, *supra* note 3. See also DAVID A. BINDER & PAUL BERGMAN, *FACT INVESTIGATION: FROM HYPOTHESIS TO PROOF* (1984) (“[T]his is due to the inherent nature of pedagogy: there are limits and teachers make choices based on their assessment of how to organize an effective program.”).

⁹ See, e.g., Minna J. Kotkin, *Reconsidering Role Assumption in Clinical Education*, 19 N.M. L. REV. 186 (1989); Ann Shalleck, *Clinical Contexts: Theory and Practice in Law and Supervision*, 21 N.Y.U. REV. L. & SOC. CHANGE 109 (1994).

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ing methods and mentoring methods must adapt to those changes.”¹⁰ ACT recognizes that clinical dynamics are evolving and that clinical teachers will constantly be making choices, affirms that these choices can be intentional and informed, and creates a structured approach that enables intentional choices to be tied to desired outcomes.

Second, the success of any model of teaching or individual clinic is necessarily tied to goals. Thus, the structure of ACT is most useful if the clinical teacher has thoughtfully considered or is aware of the importance of developing the goals of the clinic. Because this ideal is not always met, the ACT model is especially designed to address situations that reveal a lack of clarity as to the clinical teacher’s expectations, or a need to articulate an unforeseen learning goal. In these situations, ACT provides a structure that allows the clinical teacher to reflect on what the appropriate expectation is, what learning goals underlie it, and how to act accordingly. Of course, a clinical teacher can have a wide range of possible goals, and necessarily has to choose among them, but a core assumption of the model is that the teacher has or is developing clear student learning goals.

Third, a clinical teacher should meet the student where she is. This principle means that any lack of progress in the student’s learning is the clinical teacher’s responsibility and not the “fault” of the student.¹¹ The approach that maximizes student learning is one in which the clinical teacher’s choices are closely related to an assessment of the student’s individual needs, strengths, and challenges.¹² This principle of ACT is grounded in theories of adult learning and teaching that recognize that a core element of expert teaching is understanding the individual student.¹³ This focus on the student also embodies the

¹⁰ Barbara A. Blanco & Sande L. Buhai, *Externship Field Supervision: Effective Techniques for Training Supervisors and Students*, 10 CLINICAL L. REV. 611, 622 (2004).

¹¹ Hirsh, *supra* note 5 at 283 (“Whose fault is it? It would be a cruel school indeed that would think first to blame the student for his or her ability to master the curriculum.” (quoting ROBERT KEGAN, IN *OVER OUR HEADS: THE MENTAL DEMANDS OF MODERN LIFE* (1998).)); Miromi Masunaga & Maurice A. Hitchcock, *Residents’ and Faculty’s Beliefs About the Ideal Clinical Teacher*, FAMILY MEDICINE 116 (2010) (“Experienced teachers held themselves accountable for learner difficulties, whereas new teachers attributed students’ learning difficulties to an individual student’s characteristics and/or external factors.”).

¹² Blanco & Buhai, *supra* note 10, at 615-16 (describing stages of the learning process, beginning with the supervisor being more explicit and active earlier to compensate for the student’s inexperience and anxiety); Michael Meltsner & Philip Schrag, *Scenes from A Clinic*, 127 U. PA. L. REV. 1, 10-11 (1978) (“At the same time, we recognize that these are steps individuals must decide to take for themselves, at their own rates and in their own ways; like the other items on our list, personal development is intended to be a learning opportunity, not a goal that we impose on interns.”).

¹³ See, e.g., Berliner, *supra* note 4 at 202 (an element of expert teaching is understanding context, including the individual student).

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view that a successful student learning experience results in effective client representation. Clinical teachers necessarily face the complex challenge of balancing clinic design, client needs, and the student's own knowledge and skills. If the clinical teacher can effectively adapt her teaching to meet this particular challenge, then a student is a more effective lawyer and the client experiences a better outcome.

Fourth, ACT challenges clinical teachers to practice what they preach. A core element of clinical teaching is asking students to be reflective, thoughtful, and strategic in their learning and lawyering. ACT is a structured intellectual framework for teaching that enables and challenges clinical teachers to do the exact same thing that we ask of our students.

ACT itself represents a choice among philosophies. For example, implicit in ACT's core principles is the assumption that the student's education is the most important priority. It would not be unimaginable for a clinical teacher to prioritize other goals, such as a particular client's cause, over the goal of student learning.¹⁴ As a corollary, a clinical teacher could reasonably decide that a student's individualized learning needs are less important than transmitting a certain body of substantive knowledge to the entire class. Or a clinical teacher could decide that an individual student's learning is a lower priority than a conflicting learning goal for the entire group of clinic students. These differences in philosophies underscore the tension between having an objective goal – such as a client or class-wide need – and the maxim of meeting the student where she is. While the structured thinking embodied by the ACT method can still be used when the clinical teacher's goals are not primarily student-oriented, ACT assumes that the primary goal is an individualized educational one.

B. General Observations

ACT challenges the clinician to structure and focus her thinking about a teaching situation so that she can broaden and deepen her understanding of the situation and the strategies she may use as a teacher. To do so, ACT compartmentalizes reflection into six separate steps, but a few observations about the method in its entirety provide insight into its value.

First, ACT's explicit consideration of expectations enables the use of the model beyond particular supervision challenges. The approach can be used to make both reactive teaching choices, such as how to supervise a student who is constantly missing deadlines (or, on

¹⁴ George Critchlow, *Professional Responsibility, Student Practice, and the Clinical Teacher's Duty to Intervene*, 26 GONZ. L. REV. 415, 441 (1991) (noting the tension between the student's educational needs and obligations to the client).

the other hand, a student who surpasses performance expectations and thus needs new challenges), and preemptive teaching choices, such as changes to clinic design to maximize development of interviewing skills. Consistent with its core principles, the ACT model also enables the assessment or development of expectations and goals. For example, if the clinical teacher has clarity about the learning goals for the clinic and a situation suggests that progress toward the expectation is being impeded, the clinical teacher uses ACT to decide how to respond.¹⁵ On a broader level, application of the model may reveal the need for greater attention to the development of overarching learning goals that will apply to the entire clinic.

Second, the ACT approach is meant to both provide a method for teaching and create a body of knowledge on the variety of resources and approaches that the clinical teacher can reliably draw upon. Each step of the ACT method is described below using general categories, which are summarized in the chart in Appendix A. The clinical teacher can use the overview chart in Appendix A to guide her own use of ACT by filling in each column and then drawing connections horizontally across the chart to make choices as to how she will act. The categories listed in the overview chart, and described in this section, are intended to be representative rather than comprehensive listings of situations, expectations, factors and strategies. With repeated use, these charts can become a developed source of information for the clinical teacher to use in future situations.

One subset of this body of knowledge is the “factors”—the potential causes of the situation that is triggering the need for a clinical teaching choice. Teachers have instincts about what might cause a student behavior or classroom dynamic, but it is useful to consider causes beyond those suggested by intuition, and even those that run contrary to intuition, before choosing to act. By using ACT to consider a broad range of factors, the clinical teacher expands her knowledge for future teaching. Another subset of this body of knowledge is the “strategies”—that is, how the clinical teacher might act. In the same way that it is useful for the clinical teacher to reach beyond her intuition in considering factors, it is useful to consider a range of strategies before acting. Each clinical teacher likely has instinctive strategies that result from her own set of talents, skills, and experiences, but the intentional consideration of a broad set of possible strategies may provide her

¹⁵ This construct is consistent with the teaching philosophy of backward design, where the teacher chooses a goal, and then identifies the behaviors that would indicate achieving, or not achieving, that goal, and designs a classroom exercise to elicit the behaviors that achieve the goal. See GRANT WIGGINS & JAY MCTIGHE, *UNDERSTANDING BY DESIGN* (2005).

with more productive teaching choices.

Third, the ACT method explicitly addresses how all of these components work together to create a flexible process that moves beyond a conceptual framework and addresses the practical realities of clinical teaching.¹⁶ This may mean that clinical teachers use the ACT method in varying ways. Each application will uncover potential courses of action and allow the clinical teacher to better predict outcomes and, as a result, make appropriate choices. For example, a clinical teacher could develop one chart that begins with the situation of a student missing deadlines, and focuses on expectations and goals related to professionalism and another chart for the same situation, but focused on expectations and goals related to capacity to perform clinic work. Thus, the ACT method aims to provide a structure for intentional choices, language to describe them, and guidance for the variety of choices each clinical teacher makes.

III. THE ACT METHOD

Every clinical teacher can recount a situation that required thoughtfulness and action. Consider a hypothetical situation involving a law student who, before entering law school, was a paralegal at a legal assistance organization that served a low-income inner city neighborhood. She entered the clinic, which focuses on poverty law, as a seasoned advocate who quickly proved herself to be an extremely responsible, thorough, knowledgeable and effective clinic student. The student often submitted final work product without completing the detailed case plans and decision trees required by the clinic. Her documents and approach to the cases were always excellent without them. She completed work well in advance of deadlines, rarely required redrafting, and other clinic students looked to her for advice and support. In a supervisory meeting, the following exchange occurred:

Clinical Teacher: I am so impressed with your work and commitment to your clients.

Student A: Thank you. These are the clients I went to law school to serve. I worked on a lot of cases like this before I came to law school, so it wasn't terribly difficult for me to pick it back up.

Clinical Teacher: That's wonderful to hear, and I am delighted we can provide you with this opportunity. But I want to make sure you

¹⁶ A common conversation is about how clinical teachers make teaching choices that are "directive" or "non-directive," but this construct does not fully describe the rich continuum of our pedagogical choices. See Phil Schrag, *Constructing a Clinic*, 3 CLINICAL L. REV. 175, n. 171 (1996); Jane Aiken, *Ethical Manipulation*, draft on file with the authors. See also Latting, *supra* note 2 (discussing proactive-reflective continuum).

get the most out of it. In addition to representing clients, clinic is a chance to perfect your approach and legal skills. I know you have worked on similar cases in the past, and I know that you are familiar with the law in this area, but it's important that you take the time to dissect your thought process and make careful choices. Don't you agree?

Student A: I know. It's just that there are so many people who are suffering and I can't bring myself to slow down.

Clinical Teacher: I can appreciate that feeling and you're right, there are too many people suffering and without access to justice. My goal for you is to be the most effective advocate you can be to meet your own objectives. The stronger your lawyering skills are, the more successful you will be as an attorney serving a larger population of clients in the future. So, I would like to see your thought process before you start drafting documents. It is important that you start submitting your case plan prior to developing your work product. How does that sound?

Student A: I don't think anything I do will ever help enough. Take the disability case I won last week. That check is not enough for her to survive or stay safe. She is still homeless. She still has a mental illness. She is still going to be abused on the streets. It's like nothing I'm doing is making any difference at all, no matter how hard I try and how much clinic work I do. I can stop thinking about all of this. Honestly, I dream about my clients. It's all I can think about.

The clinical teacher began the supervision session focused on the assignments the student bypassed, and chose to frame the discussion as one of skill development. After the conversation, the clinical teacher, sensing the burden of responsibility the student placed on herself, might recognize how the clients' traumatic experiences affected the student's approach. The clinical teacher might focus on the student's distress and be prompted to ask, "Is there something I should do to help this student, who is emotionally distraught?" Or, the clinical teacher might identify this situation as an opportunity to learn about professional role and emotional boundaries with challenging work. The clinical teacher might also focus on the ease with which the student is accomplishing tasks and decide to provide the student with more challenging work. Any one of these actions might be appropriate, and for the clinical teacher to maximize student learning, she must engage in reflection.

ACT provides a systematic method to dissect a situation like the conversation with Student A and make intentional and productive choices to arrive at the best possible outcome. To use the method, the clinical teacher engages in six steps, abbreviated as "ADAPTS." First, she articulates her description of the situation or event that triggered

the clinical teacher's reaction that some reflection might be necessary. Second, the clinical teacher defines the expectation that is tied to the situation. This may be as straightforward as the teacher having the expectation that a particular learning goal would be met by the clinic activity, and the situation suggesting that it has not. Third, the clinical teacher gathers information and analyzes the factors, or possible causes, influences, or contexts that are affecting the situation. These factors are the key inputs for the clinical teacher's decision making. Fourth, the clinical teacher identifies or ponders the range of potential strategies for action. Fifth, the clinical teacher chooses among these strategies and acts. Finally, the clinical teacher evaluates the chosen strategy, reflects on the outcome, and shapes future choices accordingly. This final step of structured reflection may lead to repeating the ACT method to develop refined information and strategies.

Each of these steps has its own value as a structured reflection, and the entire sequence of six steps is valuable because the transition from one step to the next can provide insight into the connections between the clinical teacher's reactions, the expectations to which they relate, the context in which they occur, and the potential strategies that result.

Adaptive Clinical Teaching (ACT) Method					
A rticulate Situation <i>Describe the situation or challenge</i>	D efine Expectations <i>Identify and describe the outcome or clinic goal to be achieved</i>	A nalyze Factors <i>Identify and describe possible causes, influences, contributing factors, and contexts</i>	P onder Strategies <i>Identify potential courses of action</i>	T ake Action <i>Choose the strategy to implement</i>	S hape Strategies <i>Evaluate the outcome of the strategy and reflect on future choices</i>

A. Articulate Situations

The ACT model begins with a situation, and asks the clinical teacher to identify and describe the situation. The clinical teacher's conversation with Student A is an example. The situation is the action, event, or observation that triggers the clinical teacher's instinct that some reflection or action may be appropriate. It is the thing that makes the teacher think, "I wonder if I should do something about this?" The situation may be something as strong as a disorienting moment, as routine as the impression that a skill needs more practice or a

student's reaction is inappropriate, or as positive as a student who is excelling and may need additional challenges.

This first step is only a descriptive one, though it is closely related to the second step of analyzing the factors that contribute to the situation. The distinction is important because, by focusing only on naming and describing the situation, step one of ACT provides the framework for the clinical teacher to broadly consider the teaching situation by resisting the urge to jump to conclusions based on instinct.

Naming the first step the "situation" reflects the conscious choice that the starting point is not a "problem."¹⁷ Consistent with the philosophical basis of "meeting the student where she is," ACT explicitly suspends judgment and uses the word "situation" rather than "problem." This is because the approach is designed to be useful for all clinical teaching choices, whether planning at the beginning of the semester, dealing with an unexpected challenging student behavior, or responding to an unanticipated positive student experience. In addition, ACT embodies a philosophical choice to not construe a particular clinic event—whether it is a student behavior or a class-wide challenge—as problematic. While a clinical teacher may be prompted to use the ACT approach when an event occurs that the teacher experiences as disorienting or challenging, the underlying context and appropriate interventions are as likely to be about the teacher as they are about the student.¹⁸

There are several common categories of situations that help illustrate the concept.¹⁹ Situations may appear to fall into more than one category, and so the first step of the ACT method is for the teacher to name exactly what the situation is that is triggering the teacher's reaction. The categories described here are representative of the types of situations that the teacher may identify as stimulating the need to engage in the ACT process, but are not an exhaustive list. Each of these categories is framed as what the clinical teacher observes, because that is necessarily how the situation will be experienced. However, the subsequent stages of the ACT method embrace the view that while

¹⁷ See Mlyniec, *supra* note 3 (the "adaptive supervision" seminar at Georgetown began as a "difficult student" seminar and was then renamed to focus on the teacher's role); Stumberg, *supra* note 3.

¹⁸ *Id.* See also Fran Quigley, *Seizing the Disorienting Moment: Adult Learning Theory and the Teaching of Social Justice in Law School Clinics*, 2 CLINICAL L. REV. 37, 60-62 (1995).

¹⁹ Some of these situations parallel the "behaviors" in Stumberg's Diagnostic Model for Adaptive Supervision, though the definition and scope of the category of "situation" in the adaptive clinical teaching method varies from that of "behaviors" in the adaptive supervision model. See Mlyniec, *supra* note 3, at 532; Stumberg, *supra* note 3.

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the method begins with the clinical teacher observing a situation, understanding and addressing the situation will likely require analysis of, and action by, the teacher herself.

Productivity. Productivity situations are those where the clinical teacher observes that the form and manner of the student's performance is different from expectations. This type of situation may be one that relates to concrete expectations like deadlines or meetings.²⁰ It may be a situation related to less-defined expectations such as the length and quality of written work.²¹ Common situations include a student who misses a deadline, who turns in an incomplete draft, or, in contrast, one who completes every task easily and seems understimulated.

Cognition. "[C]linical education allows for application and response, and stretches into the most sophisticated arenas of analysis and problem solving, synthesis and internalization, and, if the program is particularly successful, into evaluation and meaning making."²² These more sophisticated cognitive demands can lead to a variety of situations in the cognition category. A common challenge is when teaching and supervising are not helping a student fully understand or synthesize concepts.²³ For example, despite seminar sessions devoted to criminal procedure and criminal law and specific supervision discussions of evidentiary burdens, a student in a criminal defense clinic continues to submit draft direct examinations of her client that include far more testimony than is in her client's interest.

Self-reflection. Clinical legal education attempts to foster students' ability to learn from experience, and many clinics explicitly engage in self-reflection exercises to develop this habit. Another type of

²⁰ See Cynthia Batt & Harriet N. Katz, *Confronting Students: Evaluation in the Process of Mentoring Student Professional Development*, 10 CLINICAL L. REV. 581, 605 (2004) (For example, a supervisor may complain that a student lacks initiative in that deadlines were missed, preparation was shoddy, and the final presentation was weak. Although the supervisor's critique appears well-supported, it is quite likely that both supervisor and student are still in the dark as to the nature of the problem); Mlyniec, *supra* note 3, at 532; Tonya Kowalski, *Toward a Pedagogy for Teaching Legal Writing in Law School Clinics*, 17 CLINICAL L. REV. 285, 341 (2010).

²¹ Margaret M. Barry, *Clinical Supervision: Walking that Fine Line*, 2 CLINICAL L. REV. 137 (1995).

²² Jo A. Tyler & Faith Mullen, *Telling Tales in School: Storytelling for Self-Reflection and Pedagogical Improvement in Clinical Legal Education*, 18 CLINICAL L. REV. 283, 290-91 (2011).

²³ See Stefan H. Krieger, *Domain Knowledge and the Teaching of Creative Legal Problem Solving*, 11 CLINICAL L. REV. 149, 151 (2004) (stating that often in clinics the students' learning is passive and they do not understand certain concepts that the teachers may think they do); Mlyniec, *supra* note 3, at 532 ("the confusion or conflation of concepts that should have been incorporated into the student's analysis of a project or case because they have been taught or researched before.").

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situation is when the clinical teacher observes that a student is not engaging in or learning from self-reflection to the extent expected.²⁴ This type of situation might appear when the teacher reads a journal entry and perceives it as rushed and shallow, or when a teacher sees a student repeat an unproductive behavior despite the teacher's interventions. It may also appear when a student is overly reflective and having difficulty grappling with his or her emotional response to the clinic work.

Communication. The communication category encompasses a broad range of clinical teaching situations. These include the clinical teacher observing an explicit communication problem such as a failure to inform a colleague of a court date,²⁵ difficulty communicating with a client, a written product that the teacher perceives as inadequate, difficulty working with fellow students, or challenges with oral presentation skills. This category also includes the teacher's observation that she is not effectively communicating with a student—perhaps feeling that she is not being heard, or noticing that she is being short with a student. Many of these situations could indicate a student's lack of progress in developing oral or written communication skills, and could also indicate situations in other categories.

Relationships. A clinical teacher may experience a situation that suggests a breakdown of relationships in the clinic. This could include the teacher's awareness that she simply does not like or does not get along with a student. Similarly, the teacher may observe students perceiving a certain relationship or power dynamic with the supervisor.²⁶

²⁴ See Mlyniec, *supra* note 3, at 533 (noting a variation in the adaptive supervision model: "The fourth category relates to cognition, which focuses on poor language skills or the inability to reflect on performance. Cognitive problems are usually the most amenable to conventional supervision. Yet in especially difficult cases, conventional methods may not suffice to achieve a legally competent performance."); Stumberg; *supra* note 3; Linda Morton, Janet Weinstein, Mark Weinstein, *Not Quite Grown Up: The Difficulty of Applying an Adult Education Model to Legal Externs*, 5 CLINICAL L. REV. 469, 490 (1999) ("The journal-writing assignment as part of the class is based in part on andragogical principles of self-reflection and experiential learning. Our hope is that, in reflecting on their externship experiences and learning, they will become more thoughtful lawyers. But there is tension when students are unwilling to engage in the process at a level we feel is necessary.").

²⁵ Jacqueline St. Joan, *Building Bridges, Building Walls: Collaboration Between Lawyers and Social Workers in A Domestic Violence Clinic and Issues of Client Confidentiality*, 7 CLINICAL L. REV. 403, 423-24 (2001) (describing a communication problem where "one student lawyer failed to inform the social worker of a court date; consequently, the social worker was unable to be in court to provide emotional support for the client. In acknowledging the difficulty of trusting a collaborator with a professional task, another student lawyer expressed her own experience that contributed to her insight on how to include the social worker in the case process. 'I knew how to do safety planning, but the social worker had a different way of doing it. I had to learn to shut up and allow her to take over.'").

²⁶ Robert J. Condlin, *Learning from Colleagues: A Case Study in the Relationship Between "Academic" and "Ecological" Clinical Legal Education*, 3 CLINICAL L. REV. 337, 374

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This type of situation may be affected by the level of intimacy and disclosure in the relationship between the student and supervisor.²⁷ The teacher might also perceive students not getting along with each other. The clinical teacher might observe “an unusual attraction to or disaffection with a client that is impeding sound case or project planning and counseling.”²⁸ This might take the form of a student who is having trouble building client relationships of trust and confidence. Finally, this category includes situations where the student struggles with understanding the relationship between a lawyer and a judge, whether in a way that the teacher perceives as unprofessional or as too deferential.

Emotions. Clinical legal education involves a high level of emotional engagement, commonly manifested as anger, hope, or excitement from involvement in representing clients.²⁹ Thus, the clinical teacher may observe a wide range of emotions in herself and in students. While the teacher may perceive some of these emotions as productive or healthy, she may perceive others as inappropriate. For example, the teacher may observe that a student is unduly frustrated, inappropriately angry, or particularly volatile.³⁰ The experience described by Robert Rader as a student in a criminal defense clinic, and the reaction of Abbe Smith, his supervisor, vividly depict the types of emotional indicators that can emerge from the clinical experience.³¹

(1997) (“[i]ndirect students were reluctant to be candid for fear that their real objectives would seem offensive or unimpressive. Competitive students, assertive as they were, still hesitated to articulate all of their views in the somewhat overstated language of advocacy for fear that such language would be misconstrued. And students going belly up did not want to do so too obviously, out of anxiety that they would appear obsequious if they were too overtly accepting of supervisor ideas, and that this, in turn, would make it difficult for them to look impressive.”).

²⁷ Kathleen A. Sullivan, *Self-Disclosure, Separation and Students: Intimacy in the Clinical Relationship*, 27 *INDIANA L. REV.* 115 (1993).

²⁸ Mlyniec, *supra* note 3, at 532. See also Alexis Anderson, Lynn Barenberg, Carwina Weng, *Challenges of “Sameness”: Pitfalls and Benefits to Assumed Connections in Lawyering*, 18 *CLINICAL L. REV.* 339, 347 (2012); Robert Dinerstein, Stephen Ellmann, Isabelle Gunning, Ann Shalleck, *Connection, Capacity and Morality in Lawyer-Client Relationships: Dialogues and Commentary*, 10 *CLINICAL L. REV.* 755, 767 (2004).

²⁹ Shin Imai, *A Counter-Pedagogy for Social Justice: Core Skills for Community-Based Lawyering*, 9 *CLINICAL L. REV.* 195, 216 (2002).

³⁰ See Anderson, Barenberg, Weng, *supra* note 28; Laurel E. Fletcher & Harvey M. Weinstein, *When Students Lose Perspective: Clinical Supervision and the Management of Empathy*, 9 *CLINICAL L. REV.* 135, 149-50 (2002); Mlyniec, *supra* note 3, at 532-33 (“[t]he third category of dysfunctional behavior is emotional. It is typically demonstrated by anger, passivity or indifference, undue frustration, pessimism, anxiety, or sometimes, hypercritical or volatile reactions.”); Stumberg, *supra* note 3.

³¹ Robert Rader, *Confessions of Guilt: A Clinic Student’s Reflections on Representing Indigent Criminal Defendants*, 1 *CLINICAL L. REV.* 299 (1994); Abbe Smith, *Carrying on in Criminal Court: When Criminal Defense Is Not so Sexy and Other Grievances*, 1 *CLINICAL L. REV.* 723 (1995).

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The student “had a terrible time,” found the work “excruciating,” “was anxious all the time,” felt “insecure” and “out of control,” and “could not relax.”³² Similarly, the teacher may observe that a student is disengaged or inappropriately passive.

Role. Situations that confront and challenge students’ conception of their professional role are a common clinic experience. Stephen Wizner eloquently describes how the experience of representing a client can trigger a feeling of personal responsibility, which grows into a sense of social responsibility “[w]hen the student realizes that, in all likelihood, the client would not have access to legal assistance but for the law student and the clinic.”³³ As students confront the ethos of zealous advocacy, work to identify their own sources of motivation and personal responsibility, and grapple with the personal cost of embracing the professional role, the clinical teacher may observe situations such as a student’s reaction that she does not want to do the type of work the clinic is engaged in³⁴ or student dissatisfaction with a case assignment or impatience with a supervisor.³⁵

Values and Ethics. The clinical teacher may encounter situations where the teacher or the student has values that are affecting the clinical experience. The teacher may observe this situation as a disconnect between or among the teacher’s, student’s, other students’, or client’s values.³⁶ The clinical teacher may also observe a related type of situation where the student’s understanding of her ethical obligations triggers the teacher’s reaction. This might occur as the perception that the student does not understand or is rejecting an ethical obligation, as a difference in understanding between the teacher and student of an ethical obligation, or as the observation of the student’s discomfort with an ethical obligation.

Difference. This category encompasses a wide range of situations, including differences in gender, race, culture, socioeconomic background, age, and values. Difference can appear in parallel ways: when students recognize difference and grapple with the role it plays in their work for clients and with colleagues and supervisors, and when students fail to recognize difference and its influence on them. The semi-

³² Rader, *supra* note 31, at 302.

³³ Stephen Wizner, *Beyond Skills Training*, 7 CLINICAL L. REV. 327, 329-30 (2001). See also Hirsh, *supra* note 5, at 283 (“We must remember that the locus of learning and development that we seek to advance resides in the learner, who will need to understand not only how to practice but who they are in practice.”).

³⁴ Rader, *supra* note 31, at 299; Smith *supra* note 31, at 723.

³⁵ Mary Jo Eyster, *Designing and Teaching the Large Externship Clinic*, 5 CLINICAL L. REV. 347, 399 (1999) (describing students reacting to externship supervision through confrontation such as requesting feedback, a discussion, or a new assignment).

³⁶ See Smith, *supra* note 31, at 735-36 (describing the experience of a student who rejects her values regarding being a public defender).

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nal examination of the role of difference in training lawyers by Sue Bryant and Jean Koh Peters articulates how difference may reveal itself through its effect on “[t]he capacity to form trusting relationships, to evaluate credibility, to develop client-centered case strategies and solutions, to gather information and to attribute the intended meaning from behavior and expressions.”³⁷ One type of situation in this category that commonly occurs is the issue of privilege. The clinical teacher may observe a student’s lack of recognition of her own privilege, struggle to understand the role of privilege, or engagement in the complex task of developing her own understanding of privilege in her client work.³⁸

Other. The categories above describe common clinical teaching situations, but cannot possibly capture the infinite situations that may arise. This variety is one of the reasons that clinic is such a stimulating learning environment.

Clinical teachers can use these categories to name and describe the situation in the first step of the ACT method. In the example of Student A, the clinical teacher may describe the situation as one of productivity, role, values, communication, emotions, self-reflection, or a combination. After thoroughly describing the situation, the clinical teacher moves to identifying the related expectations. Often there are meaningful connections between the situation and the expectations that provide insight into how the clinical teacher can proceed.

B. Define Expectations

The second step of the ACT method is to identify expectations. This step provides the framework for clinical teachers to identify the expectations related to the specific situation they are encountering, and connect these expectations to larger learning goals for clinic students. Often, the connection between the situation and the expectation is clear because the situation is itself a failure to meet a goal. For example, Student A may trigger the reaction in the clinical teacher that the goal of having students engage in reflective processes is not being met. Another example is when a student produces a letter to the client that is unclear and a learning goal for clinic students is effective written communication. Thus, the situation is one of communication or cognition in the production of the letter, which is related to the teacher’s goal of effective written communication.

³⁷ Susan Bryant & Jean Koh Peters, *The Five Habits: Building Cross-Cultural Competence in Lawyers*, 8 CLINICAL L. REV. 33, 41-42 (2001).

³⁸ Jane H. Aiken, *Striving to Teach “Justice, Fairness, and Morality,”* 4 CLINICAL L. REV. 1, 18 (1997) (As educators, we can help our students promote justice through unmasking privilege).

Sometimes, though, the connection between the situation and the expectation is less clear and requires the teacher to reflect further about her learning goals. For example, a student is speaking to a client in a manner that the supervisor perceives as unkind. The teacher could articulate this situation in different ways, including as a communication problem, as the student's discomfort with the role of lawyer, as an issue related to interpersonal relationships, or as an emotional issue. Similarly, the teacher's learning goal that relates to the situation could include developing the student's self-awareness, imparting the value and ethic of zealous advocacy, developing commitment to the client, or developing communication and counseling skills. It may be that this teacher has a variety of already-identified learning goals and simply needs to prioritize them, or it may be that the teacher has not sufficiently defined these larger goals and needs to do so. Thus, in the ACT method, the expectation step requires the clinical teacher to step back and consider what the expectations are that relate to the situation. In this example, the clinical teacher is likely to reflect on which of the learning goals are priorities with regard to this teaching situation. The expectation step provides the framework for this reflection about situation-specific expectations and their relation to larger learning goals.

There is a rich body of clinical literature regarding the range of goals a clinical teacher may have for situations that arise in the clinic.³⁹ The ACT model's step of identifying expectations necessarily tracks the larger clinical goals. Thus, a brief discussion of the categories of goals and expectations is included here to help clinical teachers using ACT to reflect on their expectations.

Capacity for Future Learning. Clinics try to teach students to learn how to learn,⁴⁰ by developing students' capacity for self-awareness and reflection.⁴¹ A related goal is developing the student's ca-

³⁹ Margaret M. Barry et. al., *Teaching Social Justice Lawyering: Systematically Including Community Legal Education in Law School Clinics*, 18 CLINICAL L. REV. 401, 407-08 (2012) ("In each context, clinical legal education introduces critical and creative thinking and the role of the lawyer by teaching reflective lawyering, professional judgment and problem-solving skills, ethical lawyering, social justice, a sense of public obligation, and collaboration."). Schrag, *supra* note 16.

⁴⁰ Laurie Barron, *Learning How to Learn: Carnegie's Third Apprenticeship*, 18 CLINICAL L. REV. 101, 103 (2011) ("Students need to be taught to 'become self-conscious . . . and self-directed in their own learning'"—a skill referred to as intentional learning."); Meltner & Schrag, *supra* note 12, at 9 ("a lawyer who learns particular skills but not how those skills are acquired is doomed to learning obsolescent knowledge"); Schrag, *supra* note 16.

⁴¹ Jane H. Aiken, *Walking the Clinical Tightrope: Embracing the Role of Teacher*, 4 U. MD. L.J. RACE, RELIGION, GENDER & CLASS 267, 269 (2004) ("I do not think it is enough to give students the experience. We need to help them reflect. We need to have them look at the experience to learn much larger lessons than what they learn when they learn how to

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capacity for critical and independent thought,⁴² and problem-solving.⁴³ When a clinical teacher has these learning goals, she is likely to have specific expectations associated with them. For example, a clinic may include iterative exercises, such as multiple moots of an oral argument, to achieve the larger learning goal that students develop capacity for reflection and self-directed learning. When the clinical teacher encounters a student who, despite repeated feedback in the moots, continues to speak too quickly, the ACT model allows the teacher to identify her expectation that moots would give the student the structure necessary for reflection and improvement.

Professional Values. This category of expectations involves developing a student's sense of responsibility, commitment to the client or zealous advocacy,⁴⁴ as well as a commitment to social justice.⁴⁵ This goal may be as abstract as inspiring students to consider fundamental social change and as personalized as simply interacting with less powerful members of society for the first time.⁴⁶ For example, using ACT a teacher might identify her goal of developing students' appreciation for issues of social justice by recognizing a situation where students rarely identify issues of social justice in their cases or seminar. Thus, the teacher's reflection reveals her expectation that students will initiate these discussions in the regular course of clinic activity, the first steps to formulating an appropriate response to the absence of such conversations.

Skill Development. Clinics frequently focus on skill develop-

handle a particular case."); Joseph A. Barrette, *Self Awareness: The Missing Piece of the Experiential Learning Puzzle*, 5 T.M. COOLEY J. PRAC. & CLINICAL L. 1, 2 (2002) ("How do our attitudes, beliefs, values, and emotions affect us as lawyers, and to what degree do they influence behavior?").

⁴² Barry et. al., *supra* note 39, at 407-08.

⁴³ Jane H. Aiken, David A. Koplow, Lisa G. Lerman, J.P. Ogilvy and Philip G. Schrag, *The Learning Contract in Legal Education*, 44 MD. L. REV. 1047, 1054 (1985).

⁴⁴ Aiken et al., *supra* note 43, at 1053 ("Our primary objective is an ambitious one: to help law students learn to accept responsibility."); Critchlow, *supra* note 14 (The clinical experience "enriches students' understanding of what it means to be a lawyer in the more subtle but important dimensions of human relations, ethical and moral responsibility (to clients, courts, and society), and reflective, self-critical thinking.").

⁴⁵ Aiken, *supra* note 41, at 270 ("Our goal for our students should be to develop a deep understanding of what it means to represent a client, how one approaches real legal problems and, especially, how the legal system often fails the poor and disenfranchised."); Aiken et al., *supra* note 43, at 1055-56 ("We do help them to understand that, as lawyers, they will have the power to affect society and at the same time we try to nurture their sense of public duty."); Stephen Wizner & Jane Aiken, *Teaching and Doing: The Role of Law School Clinics in Enhancing Access to Justice*, 73 FORDHAM L. REV. 997, 1005 (2004) ("Perhaps the best contribution that law schools can make is to sensitize students to social justice issues through limited exposure to actual victims of social injustice, and to inculcate in students the professional value of service to the underprivileged.").

⁴⁶ Aiken, *supra* note 41, at 272 ("Students feel the fear, vulnerability and the reliance of their clients inspiring them to strive to be effective lawyers with excellent skills.").

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ment.⁴⁷ These skills may be traditional ones such as trial advocacy, negotiation, writing, or client interviewing and counseling. They may also include professional skills such as collaboration.⁴⁸ A clinical teacher's skill-development expectations may be that students have certain skill levels entering the clinic or that students will see the value of a particular skill.

Client Service. The clinical teacher may have goals focused on clients rather than students. From the outset clinics have sought to serve clients and engage with their communities.⁴⁹ Thus, the clinical teacher may wish to help a particular client, support a particular cause, or more generally advance social justice.⁵⁰ Clinics may seek to translate these goals to students by focusing on the educational value of a client-centered experience or by asking students to share these goals.

Process. The clinical teacher may have goals that are related to the teaching process itself. The clinical teacher may value processes for their role in reaching other expectations, such as submitting a case plan as a freestanding expectation that leads to both client service and student learning goals. The clinical teacher may assume that the value of this process is self-evident, when in fact it is its own expectation.

Other. Of course, the clinical teacher may have other goals, related to students, clients, or the clinic, not captured by the general categories listed here.

In the example of Student A, the clinical teacher may have identified expectations related to capacity for future learning, skill development, process, or professional values. Once the clinical teacher has identified the expectations related to the situation that triggered her use of the ACT method, she moves to identification of the factors that are at work. The factors step creates the framework for the clinical teacher to understand the context in which her expectations are operating.

⁴⁷ Frank S. Bloch, *The Andragogical Basis of Clinical Legal Education*, 35 VAND. L. REV. 323 (1982) ("the goals most often cited – training law students in lawyering skills, introducing students to the full scope of the legal system and its actors, and developing in students an understanding and appreciation of professional responsibility issues – all emphasize the ability to offer new areas of substantive learning as the primary, if not exclusive, value of clinical legal education"); Meltsner & Schrag, *supra* note 12 at 8-9 ("The opportunities the clinic offers for the development of legal skills are impressive.").

⁴⁸ Aiken et al., *supra* note 43, at 1054-55 (identifying collaboration as a learning goal).

⁴⁹ Wizner & Aiken, *supra* note 45, at 997-98 ("They also observed the lack of practical involvement of the law schools in the rights revolution sweeping the courts and communities of America. One of the primary reasons for having a clinic was to engage a law school more directly in providing that representation.").

⁵⁰ *Id.*

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C. *Analyze Factors*

The next step of the ACT model is to analyze the factors that contribute to the situation. In this step the teacher identifies the situation's interactions, backgrounds, personalities, differences, and contexts. Although articulating the situation is the first step, the factor and situation steps are closely related. Implicit in the articulation of situations is some assessment of what factors are at play. The guiding philosophy behind the factors step—and its sequence after reflection after the expectations step—is that context is a crucial part of the analysis.

While much of factor analysis will focus on the clinical teacher's instincts, external sources are also critical. Clinical teachers should develop a body of knowledge, drawing on other clinical teachers' experiences, social science research, and experts from business, medicine, psychology, education, and other professions. Clinical teachers can also gather information from the students themselves through individual or group inquiry or simply through observation.

Many clinical teachers may instinctively focus on a single factor when engaging in the ACT model. This is understandable, as identifying a single cause for a single behavior is a simple way to approach any situation. Situations, expectations, and factors rarely exist in isolation, though, so interconnectedness of different factors may be as important as identifying a single causal factor. When engaging in ACT, teachers should always be alert for alternate or layered factors. As with situations and expectations, examples of factors help to illustrate this step.

The Clinical Teacher. Consistent with the underlying philosophy of ACT, a key factor is the teacher herself. Factors may include the teacher's age, race, culture, personality, teaching style, lawyering experience, biases, emotions, and available time. Supervisors have “candidly identified instances when their personal likes and dislikes of particular students affected their ability to address professional development issues” and “spoke of the difficulty of helping a student to develop an individual lawyering style when it might contradict the supervisor's own lawyering style.”⁵¹ Clinical teachers may even feel that some students warrant more effort than others.⁵² This factor can be experienced in a range of ways by the teacher, from “difficulty of establishing rapport with some students” to “a bad mix of personali-

⁵¹ Batt & Katz, *supra* note 20, at 604.

⁵² *Id.* (“Another practitioner suggested that it was difficult to invest the energy in students perceived as “difficult” or “very limited.” “Poorer students aren't worth the time,” said one supervisor.”).

ties.”⁵³ The impact of this factor may also manifest in the level of intimacy between student and teacher, which may stem from factors such as gender or age.⁵⁴ In addition, the clinical teacher’s emotions can be a factor in many dynamics with students.

The Clinic. This factor includes the pedagogical approach of the clinic, the clinic’s subject matter, the workload, the supervision structure, or the nature of expectations and deadlines. Factors relating to the clinic necessarily interact with the broader law school experience. For example, the clinic’s workload and time commitment exist in the context of the student’s other courses and commitments.⁵⁵ The clinic’s pedagogical approach is a powerful factor in this category. For example, if the clinic has explicitly adopted a non-directive supervision model, that choice may be a crucial factor in a student’s clinic experience.⁵⁶

The Client. The client’s culture, language, socioeconomic status, intellectual and emotional capacity, personality, values, investment in the representation, or relationship with the student or supervisor are all factors to consider. For example, clinic students often struggle with clients in emotional distress.⁵⁷ This challenge could be a factor in a range of indicators from students’ overinvestment in the client’s personal life to resistance to interacting with the client.

The Student. Student factors can include cultural background, generational influences, language, personality, expectations, professional and personal experiences, ability to handle stress, and interpersonal skills. Each of these factors can exist in a single student, who is the focus of the situation, or in other students who are part of the context of the application of the ACT method.

Some specific types of student factors warrant a brief mention. One of these is disability, which may squarely present itself when a student self-identifies a disability or may be more complicated, such as when the clinical teacher believes that a non-visible disability, such as

⁵³ *Id.*

⁵⁴ Sullivan, *supra* note 27, at 115, n. 7 (noting the role of age and gender in levels of intimacy between clinical supervisors and students, and discussing the applicability of feminist scholarship about gender, distance and connection).

⁵⁵ Batt & Katz, *supra* note 20, at 602 (“several supervisors talked of students who failed to manage their time well, resulting in conflicts and stress with other commitments. Some students had difficulty adhering to the time requirements of the program and had difficulty arriving as scheduled or working the requisite number of hours. Other students appeared to their supervisors to have so many conflicting demands that even when they put in the appropriate amount of time, they did not appear invested or committed to the work.”).

⁵⁶ Fletcher & Weinstein, *supra* note 30, at 150 (“For those clinics adopting a non-directive supervision model, i.e. where the pedagogic priority is to maximize student learning by giving the student primary responsibility for strategic decisions, how the supervisor intervenes is critical.”).

⁵⁷ *Id.*

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a learning disability, depression, or an anxiety disorder, is present.⁵⁸ This category of factors presents particular challenges in identification and, as discussed below, particular sensitivities when identifying appropriate strategies for the teacher. Another specific student factor is a history of trauma, which a student may or may not explicitly reveal. The significance of a student's history of trauma, and how the clinical teacher addresses it, may vary widely.⁵⁹

A final key factor in this category is the student's own learning process. Stemming from ACT's underlying philosophy that the teacher should meet the student where she is, the most important factor may be student engagement in learning. Productive learning often results from confusion, so when a clinical teacher faces a situation of student confusion, the student's own learning process is a factor.⁶⁰

The factors step is often the richest part of the ACT method, as the clinical teacher may see a number of factors immediately, and upon further reflection may identify even more. For example, with Student A, the teacher may immediately note that Student A's reaction to her clients' traumatic experiences is affecting her choices, but may not make the connection that her previous work experience was affecting her current client work. Or the clinical teacher, upon reflection, may identify that the reasons for her own focus on deadlines and assignments were not clear to, or shared by, Student A.

⁵⁸ See Alexis Anderson & Norah Wylie, *Beyond the ADA: How Clinics Can Assist Law Students with "Non-Visible" Disabilities to Bridge the Accommodations Gap Between Classroom and Practice*, 15.1 CLINICAL L. REV. 1 (2008); Leah M. Christensen, *Law Students Who Learn Differently: A Narrative Case Study of Three Law Students with Attention Deficit Disorder*, 21 J. L. & Health 45 (2008); Leah B. Lipskar, *Learning Disabilities and the ADA: A Guide for Successful Learning Disabled Students Considering a Career in the Law*, 3 U. PA. J. LAB. & EMPL. L. 647 (2001); Mlyniec, *supra* note 3, at 535 (discussing psychological categories); Stumberg, *supra* note 3.

⁵⁹ See, e.g., Anderson, Barenberg, Weng, *supra* note 28, at 384 ("Prior to the hearing, Marie had disclosed to Bill that she had been raped and, as a result, the team reallocated some of the work for the hearing. Specifically, Bill handled that portion of their client's direct testimony about her arrest, imprisonment, and rape."). See also Lisa McCann & Laurie Anne Pearlman, *Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims*, 3 J. TRAUM. STRESS 131, 131-33, 144-47 (1990) (describing vicarious traumatization as "related both to the graphic and painful material trauma clients often present and to the therapist's unique cognitive schema or beliefs, expectations, and assumptions about self and others" and recommending tools by which helping professionals can handle client histories of trauma, while protecting their own mental health).

⁶⁰ See Catherine H. Crouch and Eric Mazur, "Peer Instruction: Ten Years of Experience and Results," AM. J. PHYS. 69, 970 (2001); Kurt VanLehn, *Cognitive Skill Acquisition*, 47 ANN. REV. PSYCHOL. 513-539 (1996); Sidney D'Mello et. al., *Monitoring Affective Trajectories During Complex Learning*, in D. S. McNAMARA & J. G. TRAFTON (EDS.), PROCEEDINGS OF THE 29TH ANNUAL COGNITIVE SCIENCE SOCIETY 203-208 (2007).

D. Ponder Strategies

The first three steps of the ACT model are focused on information gathering and reflection. The fourth and fifth steps—ponder strategies and take action—concern the clinical teacher’s choice and subsequent action. The strategies step identifies possible actions to meet the stated expectation, in light of the situation and factors. These strategies naturally flow from the factors, and like the diagnosis steps, the intentionality of identifying the range of possibilities is a crucial part of the model. Like factors, the combination of the clinical teacher’s reflection and external sources of information produces the most effective results.

Supervision. One set of strategies involves supervision choices. Clinical scholarship and teacher experience provide a range of supervision strategies.⁶¹ For example, “[t]he teacher may strengthen the supervision by diminishing his or her emotional reactions to the student or to the behavior and focusing only on the tasks and the impediments to their completion.”⁶² Or, she “may adopt a different method of supervision, using more directive or modeling techniques.”⁶³ Similarly, “[t]he teacher may need to provide additional substantive information and may need to be clearer in his or her explanation of the material.”⁶⁴ In addition, a teacher may wish to take a step back and clarify explicitly, in collaboration with the student, the student’s objectives and plan.⁶⁵

⁶¹ Blanco & Buhai, *supra* note 10, at 611; Liz R. Cole, *Training the Mentor: Improving the Ability of Legal Experts to Teach Students and New Lawyers*, 19 N.M. L. REV. 163 (1989); Mlyniec, *supra* note 3, at 535.

⁶² Mlyniec, *supra* note 3, at 535. See Anderson, Barenberg, Weng, *supra* note 28, at 361 (“To avoid the risks of overidentification, Nadal’s supervisor must help Nadal to acknowledge and make explicit his reactions to his client, identify the source of those reactions (assumptions of sameness), and recognize the impact that those assumptions have on his relationship with his client and his lawyering judgments.”); Ian Weinstein, *Teaching Reflective Lawyering in A Small Case Litigation Clinic: A Love Letter to My Clinic*, 13 CLINICAL L. REV. 573, 601 (2006) (“The emotional power of these issues is attractive to many of us, yet also impedes my efforts to teach material in the classroom or through less intensively supervised experiential learning.”).

⁶³ Mlyniec, *supra* note 3, at 535. See James H. Stark, Jon Bauer and James Papillo, *Directiveness in Clinical Supervision*, 3 BOSTON U. PUB. INT. L. J. 1 (1993).

⁶⁴ Mlyniec, *supra* note 3, at 535. See Leah Wortham, *The Lawyering Process: My Thanks for the Book and the Movie*, 10 CLINICAL L. REV. 399, 456 (2003).

⁶⁵ Blanco & Buhai, *supra* note 10, at 622 (“often the failed relationship is the failure of the supervisor to recognize that the parties’ roles and dynamics change throughout the learning process and that supervising methods, teaching methods and mentoring methods must adapt to those changes. Adoption of the Eyster model, in which students clearly communicate learning objectives to the field supervisor, may lead to more shared responsibility for effective supervision when students and supervisors agree on the goals and objectives of the experience, and supervisors and students have a macro-plan for the semester so that they both understand the respective expectations and goals for the time period.”); Cole, *supra* note 61, at 164-68 (Mentors are encouraged to provide effective feedback and be

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Classroom Teaching. It may be that the situation is best addressed through seminar sessions. These strategies might involve dedicating classroom time to common issues in supervision, addressing gaps in substantive knowledge, or allowing students to model reflective processes for each other.⁶⁶

Clinic Structure and Operation. If the situation, expectations, and factors identified suggest a broader approach, then clinic operations may be a productive area of action. These strategies may include something as simple as adjusting workloads and case assignments.⁶⁷ The design of the clinic may be at issue because “cases may be too complex for a clinic course” or “[t]he complexity of the subject matter of clinic cases may require changes in student selection process of the clinic.”⁶⁸ Or the case team assignments might need to be changed.

Student Role. If the situation, expectations, and factors suggest student distress, the teacher may want to address student role. For example, the clinical teacher may choose to adjust the expectations for the student.⁶⁹ The teacher may also engage other types of support for the student, such as referrals to services outside the clinic.⁷⁰ These strategies may also include explicitly talking and collaborating with the student to define or redefine the student’s role.

Do Nothing. This final strategy is one that clinical teachers can easily overlook. It flows from the observation in the discussion of factors that the situation may be a part of the student’s learning process and the best strategy is to simply do nothing and let that process continue. This is consistent with learning theory and research that suggests productive learning results from confusion.⁷¹ It may be that the student is in the stage of learning that involves confusion or emotion,

invested in the students’ micro and macro planning for their externship experience).

⁶⁶ Mlyniec, *supra* note 3, at 535 (“[p]erhaps the clinic curriculum needs to be revamped to account for issues not seen before.”); Peter Jaszi, Ann Shalleck, Marlana Valdez, Susan Carle, *Experience As Text: The History of Externship Pedagogy at the Washington College of Law, American University*, 5 CLINICAL L. REV. 403, 414-15 (1999).

⁶⁷ Mary Helen McNeal, *Unbundling and Law School Clinics: Where’s the Pedagogy?*, 7 CLINICAL L. REV. 341, 401 (2001) (describing curricular challenges within clinics); Mlyniec, *supra* note 3, at 535.

⁶⁸ Mlyniec, *supra* note 3, at 535.

⁶⁹ Mlyniec, *supra* note 3, at 535. *See also* Carolyn R. Young & Barbara A. Blanco, *What Students Don’t Know Will Hurt Them: A Frank View from the Field on How to Better Prepare Our Clinic and Externship Students*, 14 CLINICAL L. REV. 105, 122 (2007).

⁷⁰ Mlyniec, *supra* note 3, at 534 (“Students with serious emotional or mental health issues may need to be referred to appropriate professionals to address those needs.”).

⁷¹ *See* Crouch & Mazur, *supra* note 60, at 513-539; D’Mello et. al., *supra* note 60, at 203-08; JACK MEZIRROW ET AL., *FOSTERING CRITICAL REFLECTION IN ADULTHOOD: A GUIDE TO TRANSFORMATIVE AND EMANCIPATORY LEARNING* (1990) (discussing the “critical theory” of adult learning that is based on the ability to scrutinize your own and your culture’s values, assumptions, and beliefs and question what you might have passively assimilated in order to engage in transformative learning).

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and that as the process continues—without intervention—the learning that is consistent with the teacher’s expectation will naturally occur.

In the example of Student A, the clinical teacher may identify a range of strategies, including changing her supervision style to a more transparent one so that Student A has an opportunity to understand or disagree with the importance of deadlines and interim case steps. The clinical teacher may also decide to engage the student in a conversation about how she is experiencing her clients’ problems, and how her previous work experience informs that experience. The clinical teacher may also use a broader strategy such as engaging students in a seminar discussion on developing an ability to manage and balance client needs with your own. Finally, the clinical teacher may alter the design of the clinic by creating an explanation of the reasons for deadlines and interim assignments in the course materials.

E. Take Action

The first four steps of the ACT method require the clinical teacher to gather information, name, reflect on, and identify alternatives. Each of these steps embraces the underlying philosophies of the model by being intentional and focused on the student. The fifth step of the ACT method requires the teacher to choose—because as a clinical teacher “you can do anything, but you cannot do everything.”⁷²

Once the clinical teacher has identified the range of strategies, how does she choose? The ACT method encourages intentionality, a necessary step.⁷³ If the clinician has created her own ACT matrix, she may want to draw connections among the various situations-expectations-factors-strategies to help her focus on which strategy addresses which goal.

The clinical teacher’s choice is necessarily tied to prioritization of goals. If there is a goal that the teacher values above others, then the strategy directed at this expectation is the logical choice. In addition, the clinical teacher must consider resources. There is finite supervisor time, and so the teacher may choose strategies that maximize individual interactions and use classroom time efficiently.⁷⁴ Similarly, the

⁷² Thank you to Tirien Steinbach for sharing this phrase that encapsulates an inherent truth of clinical teaching, and of social justice lawyering.

⁷³ Kotkin, *supra* note 9; Mlyniec, *supra* note 3, at 523 (“The main lessons to be learned are that supervision is intentional, that choices have to be made, and that techniques have to be appropriate.”).

⁷⁴ Mark Neal Aaronson & Stefan H. Krieger, *Teaching Problem-Solving Lawyering: An Exchange of Ideas*, 11 CLINICAL L. REV. 485, 491-92 (2005) (“In making my choices, I tend to emphasize what students are not likely to get in their other courses.”); Shalleck, *supra* note 9, at 148-49 (“supervision is a very time-intensive method of teaching. When a

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teacher and student have finite capacities to teach and learn.⁷⁵

An often-implicit part of a teacher's choice of strategies is the teacher's instincts about the student's receptiveness to one type of intervention over another. The ACT step of identifying factors may offer helpful input, as it can test the teacher's instincts about student receptiveness.

F. *Shape Strategies*

Consistent with ACT's philosophy of structured reflection, the final step in the method is to reflect on the strategy chosen and shape future choices. It may be that the first strategy attempted by the clinical teacher does not work, and so she must try another strategy. It may also be that the clinical teacher has multiple expectations to address and thus multiple strategies are appropriate. More than one strategy may be required to address a multifaceted situation. So the final step of ACT is its own reflection and assessment of the clinical teacher's experience using the previous five steps of the process.

This final step may require the clinical teacher to go back to the ACT chart she developed and look at other paths revealed by situation-expectation-factor-strategy connections in her initial structured reflection. If the first choice of strategy is not effective, what does that say about the factors and strategies originally considered, and how does that inform the choice about the next strategy? Or, if the first strategy is only partially effective, what additional strategies can she implement?

It may also be that the implementation of the clinical teacher's chosen strategy reveals new information, essentially creating a new "situation." The clinical teacher can use the ACT method again from the beginning to refine her understanding of the situation, factors, and expectations to refine her strategies.

Finally, the clinical teacher's reflection may reveal new resources and approaches that she can reliably draw upon. The clinical teacher's deliberate approach to the situation may allow for the identification of the factors that frequently trigger situations. The clinical teacher might try new strategies to respond to the situation. Ultimately, shaping strategies through reflection and analysis will result in the development of a body of knowledge to use during ACT.

goal can be achieved more efficiently in another course component, supervisory time should not be used. It is important to be constantly alert to, and creative about, ways to teach effectively through classes and group meetings.").

⁷⁵ Aaronson & Krieger, *supra* note 74 ("The choices we make regarding how and what to teach are critical. There are issues of trying to do too much at once, something which Krieger refers to as cognitive overload.").

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IV. ACT APPLIED

This section offers a second teaching hypothetical to demonstrate the ACT method in action. The ACT method applies to a breadth of supervision and teaching scenarios. By way of example, this section illustrates how the method helps address an individual situation, as well as how it broadens and deepens the teacher's effectiveness. Assume that the same Student A, who was described at the outset of Section III, is partnered on a case with Student B. Student B has demonstrated his understanding of the clinic subject matter by accurately and frequently responding to questions on readings during the seminar component of the clinic. The clinical teacher, impressed with Student B's recall and hoping to pair a strong student with Student A in order to challenge her, placed Students A and B on a team to represent a client. The following exchange occurred during a supervisory meeting:

Student A: We did a phone interview with the client and talked about the Food Stamp issue she came to the clinic with, but also learned that her landlord wants her to vacate her apartment by Friday. I would like to move forward immediately before the landlord proceeds with a self-help eviction, which in my experience is highly likely in this case. I have prepared a letter to send to the landlord, but Student B thinks we should wait.

Clinical Teacher: What do you think, Student B?

Student B: Isn't this outside the objective you gave us? The original case assignment was to appeal her Food Stamp denial. During orientation you told us we should stay focused on one case at a time and that you would assign us other cases when we were ready. I feel like the client has two issues, and we were told to work on one issue and aren't ready for a new assignment. It is important to me to successfully complete our original assignment. I told the client that we would tell you about the housing situation to see if any of the student teams had room to take the case.

Clinical Teacher: What did the client say when you told her the eviction wasn't your assignment?

Student A: It was hard to understand her because she was crying and very distraught and couldn't focus. She just kept repeating, "Where are my babies going to sleep?"

Student B: I tried to distract her from what was upsetting her by focusing the conversation on the Food Stamps appeal.

Clinical Teacher: Have the two of you discussed how these two issues might affect your client?

Student A: No, we were just trying to calm her down.

Student B: And trying to figure out what to do next to resolve the original issue.

Clinical Teacher: Okay, so what is your proposed plan?

Student B: I don't know. I want a successful outcome for the client so I thought I would start with research on Food Stamps. I'm confident I could conduct a brief review of the law and prepare a legal memorandum on her case.

Clinical Teacher: Do you have a sense of what deadlines you are facing?

Student B: Is there a filing deadline we should know about? Did you include that in our materials? I didn't see anything like that.

Student A: Well, her landlord says he is kicking her out Friday, but I don't know what that means for court deadlines.

Clinical Teacher: Research and deadlines aside for now, what do you want to do as a team?

Student A: I would like to visit the client's apartment and determine if we have any defenses to the nonpayment of rent and then contact the landlord. I think I can be more supportive to her in person, too.

Student B to the Clinical Teacher: I'm okay doing that if you want us to, but I just don't feel comfortable doing anything without more direction. I'm confused about what you expect us to do. Can you tell us what you think we should do?

A. *Articulating the Situation*

The clinical teacher begins by identifying and describing the situation presented. The clinical teacher's initial description may closely track her instinctive response to the situation, but by applying the initial step of the ACT method, she can challenge herself to broaden her understanding. Here the clinical teacher's initial reaction may be one of frustration with Student B, and her instinct is to challenge him to expand his thinking and deepen his commitment to the client. She might ask a series of questions to press Student B on why he is looking to her for direction and why he is gravitating towards the originally "assigned" issue. ACT requires a broader description of the situation, to lead to a more intentional strategy.

Communication and Relationships. First, the teacher describes communication or relationship issues in this exchange. Student A and Student B are having difficulty communicating and are struggling to reconcile their different understandings of the client's needs, and their next steps. The teacher also notes that there may be a communication issue between the students and the client about the client's needs. The clinical teacher also wonders whether she is communicating effec-

tively with the students. Finally, she thinks the students may be having trouble developing their collaborative relationship, which she describes as communication problems and also the interaction of two different working styles.

Role. The clinical teacher also sees the students struggling with their professional role. She describes Student B as disengaged from the client's situation and not embracing the role of zealous advocate. She describes Student A as taking on too much personal responsibility and not focusing on how the client identifies her own needs and interests. The clinical teacher also sees Student A as proactive and independent and Student B as relying on the supervisor for direction. She describes Student A as more comfortable with uncertainty and Student B as seeking clarity before moving forward.

Cognition. Finally, the clinical teacher identifies that the students are struggling to understand how the client's different needs and potential solutions are related. She describes that the students see two separate paths – pursuing food stamps and resolving the housing issues – but not how these paths affect each other. The clinical teacher also identifies that the students are gravitating towards solutions that best match their own comfort with process and substantive law – housing issues for Student A and a clear food stamp appeal process for Student B.

Through the subsequent steps of the ACT method, the clinical teacher can broaden her understanding of the situation, gain insight into the potential complexity of factors at play, and identify strategies for intervention. But before the clinical teacher investigates the factors at play, she needs to be clear about her own expectations.

B. Defining Possible Expectations

After describing the situation, ACT asks the clinical teacher to clarify her expectations. The clinical teacher in the example identifies several relevant expectations.

Commitment to Clinic Mission. First, she identifies her expectation of commitment to clinic work as relevant to the situation, stemming from the core clinical mission of providing students with the opportunity to learn from experience. She believes that students must commit to clinic work and understand the consequences of their decisions. Students who embark on their clinical experience with an open mind and positive attitude often reap greater benefits from the experience than those who are skeptical, question the clinical model, or rebuff client responsibility. The teacher worries that Student B's commitment to clinical work is deteriorating, and she perceives this as inconsistent with his clinical opportunity.

Capacity for Future Learning. The teacher wants her students to develop their capacities for future learning, critical and independent thought, and problem solving. She has the common goal of developing critical and independent thinkers who are adept at problem solving and have the capacity for lifelong learning.⁷⁶ She believes that the hallmark of a good attorney is the ability to engage in critical, independent and creative thought, and that this requires the ability to “(1) recognize those occasions when doing a task by the book is not likely to achieve satisfactory results, (2) figure out a creative alternative, and (3) find the courage to deviate from the accepted norm of practice.”⁷⁷ Attainment of these goals often requires students to scrutinize their decisions and subsequent actions. The clinical teacher has the expectation that these skills will develop through supervision. The clinical teacher identifies that the situation with Student A and B suggests that these expectations are not being met.

Self-evaluation and Reflection. Encouraging self-evaluation and reflection are also goals, because they are critical to a student becoming a lifelong learner. The clinical teacher believes that clinic is one of the few legal settings in which time is set aside to analyze and critique performance in order to improve the student’s skills. The teacher hopes that students will reflect on their experiences lawyering, interacting with the justice system, and realizing their own personal professional philosophy. The clinical teacher identifies that these expectations are not being met here because the students are not reflecting on their own choices, either on their own, with each other, or with the teacher.

Professionalism. The teacher expects that her students will be timely and professional because clinics cannot represent clients, contribute to public policy, or plan appropriately if students are not dependable. The consequences of unplanned delay could be devastating to the clinic’s clients and the reputation. Untimely and unprofessional clinic students are also unlikely to have successful legal careers. Students A and B are not aware of, and thus may not meet, relevant deadlines. This situation connects to broader expectations of professionalism, both in terms of the students’ interaction and relationship with their client and with how they are handling their case decisions.

Communication Skills. Finally, teacher expects effective communication. Effective communication skills, including oral, written, and interpersonal skills are foundational to individual and organizational success. These expectations are not being met between Students A and B, between the students and the teacher, and between clinic and

⁷⁶ Schrag, *supra* note 16, at 181.

⁷⁷ Schrag, *supra* note 16, at 185.

client. The teacher may also have concerns about the quality of the written communication the students will develop based on their incomplete research proposal.

C. Analyzing Factors

The ACT framework challenges the clinical teacher to use her descriptions of the situation and her expectations to broadly consider the factors at play. The ACT framework suggests that the teacher analyze the factors related to Students A and B under the general categories of the teacher, the clinic, the client, and the student to structure this stage of reflection.

The Clinical Teacher. The ACT framework suggests consideration of the teacher herself first, because it allows the teacher to see factors that she instinctively frames as student traits or problematic behavior from another perspective. In this situation, the teacher identifies that she has an easier relationship with Student A, because they are of the same gender, closer in age, and were both paralegals for legal services providers before law school. The teacher also realizes that she is frustrated by the divergence between the students' actions and what she would do. For example, she believes that zealous advocacy requires addressing all of a client's needs, and so is frustrated by Student A and Student B because they each are focusing on only one need. The teacher also believes that providing emotional support for the client is crucial, and is irritated that the students seem not to be prepared to do this for the client. The teacher also identifies that, unrelated to Students A and B, preparing for a conference is draining her attention and time and compounding her frustration.

The Clinic. The clinical teacher identifies that the clinic's seminar component focuses only on the process of food stamp appeals, so the students have limited substantive or procedural knowledge for strategizing about the client's needs. The clinic also does not provide classroom teaching around relating to emotional clients, so Students A and B are encountering this challenge in clinic for the first time. The clinical teacher has also made the pedagogical choice to give students free rein over the needs they identify and solve for a client, and that choice is an important factor in this situation. She also identifies that her rigid approach to clinic procedures, especially during orientation, may be in conflict with her other choices.

The Client. The students have described that the client was very emotional. The clinical teacher's assessment is that this factor may be affecting the situation in a number of ways, including distracting the students from information gathering, drawing their focus to the legal need that seems most closely tied to the client's emotions, and creat-

ing their own emotional distress.

The Student. Finally, the clinical teacher identifies factors related to Students A and B. The clinical teacher has observed that Student A is an external processor who likes to talk about ideas before they are fully formed, while Student B is an internal processor who takes time to think carefully before making suggestions. The clinical teacher also identifies that Student A is older and more experienced, while Student B is younger and less experienced, and this has created a dynamic where Student A rarely listens to Student B. Finally, the clinical teacher has identified that Student A tends to be an intuitive and creative thinker while Student B focuses more on logical planning.

D. Potential Strategies

The factors described above create the context for the clinical teacher's application of the ACT method. This section focuses on how understanding the breadth of factors can help the clinical teacher identify strategies beyond those that she has used previously or might instinctively use. The clinical teacher's initial reaction to the conversation with Students A and B was to use questions in a supervision meeting to stimulate Student B to understand why he is seeking so much direction, and to challenge him to expand his thinking and his commitment to the client. After using the ACT framework to expand her understanding of the situation, her expectations, and the factors at play, the clinical teacher may identify other potential strategies.

Supervision to address professional role and emotions. One strategy the clinical teacher identifies draws on her insight about the role of emotion – her own, the students', and the client's – in this situation. She could use the situation to help the students develop their skills for working with the emotions involved. Pursuant to this strategy, the teacher engages the students in role play scenarios, where the students have to act as the client. The experience of embracing the client's perspective gives the students an opportunity to engage in parallel universe thinking that may help them better understand the client's communication choices, experience of her legal needs, and priorities.⁷⁸ These simulated conversations can also allow the students to develop their own skills in talking to an emotional client—both in terms of establishing rapport and in gathering information. Simulations also teach independent and strategic thinking. As the student address a series of scenarios and model the client's reaction to their proposed solutions, the students learn to think strategically about how their

⁷⁸ See Bryant & Peters, *supra* note 37.

choices lead to outcomes. These exercises also provide an opportunity for the clinical teacher to stimulate reflection on the part of the students about how their own emotional reactions are affecting their lawyering choices.

Supervision to address collaboration. A different strategy addresses the different working styles of Student A and Student B. The clinical teacher first asks the students to individually write a structured reflection that summarizes the information they have, the questions they have and information they need, and the choices they could make. After the students complete their individual reflections, she asks them to discuss the similarities and differences in their reflections together, and then with the teacher. Then the teacher asks the students about the value of this exercise, using this opportunity to draw out Student A's external processing and intuitive thinking style, and Student B's internal processing and logical thinking style. Through this strategy, the clinical teacher allows for both students to work together to maximize their contributions, and then guides them through reflection about how they can use this model going forward. This strategy also implicitly addresses the factor the clinical teacher identified in herself, which is that she relates better with Student A and is frustrated with Student B, and created a framework that accommodates Student B's strengths. This strategy may also provide an opportunity for Student B to prove himself, which may shift the dynamic in the relationship between the students.

Classroom teaching to address skill development. The clinical teacher identifies a third strategy for the clinic's design, specifically the seminar sessions. Neither student had developed skills in the areas of handling emotional clients or clients with multiple legal needs. To address this, the clinical teacher could design seminar sessions to address both sets of skills. A first seminar session could address the interpersonal, interviewing, and counseling skills involved in talking to an emotional client. A second seminar session could address common needs beyond food stamps that students may see in their representation, and how students can think about and make choices regarding these other needs. In addition, she could revise orientation to provide greater clarity about what cases and situations the students might encounter in the clinic and the ways in which their caseload and priorities might shift throughout the semester depending on client needs.

Classroom teaching to stimulate reflection. Another strategy the clinical teacher identifies combines the specific needs of Students A and B with a seminar session, by asking the students to present their

choice of how to address their client's needs in a case rounds session.⁷⁹ This case rounds session would use a structured method of group inquiry – first the students present their dilemma, then their colleagues gather facts about the dilemma, then the class attempts to diagnose what the problem is, then the class generates solutions. This approach reinforces that the students should deepen their understanding of the clients needs, provides a model for future problem-solving, and generates specific solutions for moving forward. This strategy is consistent with the clinical teacher's expectations regarding reflection and independent learning, the pedagogical choice to give students control over their choices, and may stimulate the students to meet the expectation of increased commitment to their client.

Do Nothing. Finally, the clinical teacher identifies the strategy of doing nothing and proceeding with supervising the students' case work. This strategy assumes that the situation with Students A and B is not that different from situations she has seen before with students and the students may work out their communication, client relationship, and strategic issues on their own as they move forward with their representation in the existing clinic framework. This strategy is consistent with the teacher's expectations of commitment and independent learning, and also with the pedagogical choice to let the students have full ownership of their decisions.

E. Taking Action

Having identified possible strategies, the clinical teacher must choose how to respond to Students A and B. Through her use of the ACT method, she is able to appreciate the breadth of factors affecting the situation that has presented itself and she has generated a range of strategies based on this intentional reflection. Often, the ultimate choice among strategies is tied to the expectation that the clinical teacher wants to prioritize – whether it is independent learning, developing emotional caretaking skills, developing collaboration skills, or generalized learning for the entire group of clinic students. In this example, the clinical teacher decides that she wants to focus on the students' differing work styles because she believes this will enable more independent learning and commitment to the client going forward, and so she pursues the strategy of creating a working model for the students that enables both styles of thinking. Regardless of the goals prioritized or the strategy selected, however, ACT encourages deliberate and thoughtful teaching choices based on all the relevant

⁷⁹ See Susan Bryant & Elliott S. Milstein, *Rounds: A Signature Pedagogy for Clinical Education?*, 14 Clin. L. Rev. 195 (2007).

information. Once the teacher decides, she cannot guarantee success, but she can feel confident that her strategy was well thought out and reflective in the tradition of clinical teaching itself.

F. Shaping Strategies

After implementing the chosen strategy, the final step of ACT asks the clinical teacher to reflect and shape future choices. Having implemented the chosen strategy, the clinical teacher sees that Students A and B seem to be listening to each other more, and the students reach the decision that they will pursue both the food stamp appeal and negotiation with the client's landlord. Thus, the chosen strategy seems to have had success in resolving the conflicting working styles, and has led the students to embrace their advocacy of the client more fully.

However, in the supervision session where the students are reporting on this progress and planning how to talk to the client about it, the clinical teacher observes that the students are not thinking about the client's emotional state. The clinical teacher realizes that she may need to implement a revised version of one of her strategies regarding the client's emotions. Through this final step of ACT, the clinical teacher decides to engage in some modified role play scenarios with the students to help them think about the client's perspective and to develop skills for counseling the client. The clinical teacher also decides that, although she will not use a seminar session to develop skills for interacting with emotional clients now, she will design one for next semester's students. Overall, the process has alerted her to factors she can now readily identify in the future and provided her with strategies to rely upon in subsequent semesters and with future clinic students.

V. CONCLUSION

Clinical teaching is an exercise in constant adaptation, and clinical teachers rely on strategies ranging from defined pedagogy to instinctive reactions to maximize student learning. The reality of clinical teaching may be that a teacher feels like "I sometimes don't know where the method ends and the madness begins. Sometimes I make it up as I go along."⁸⁰ The ACT methodology creates a structured method for the madness. It provides the clinical teacher with a guided reflection for clinical teaching—whether it is clinical design or a supervision session—so that she bases her teaching choices on as much knowledge and intentionality as possible.

⁸⁰ Smith, *supra* note 31, at 736.


The example described in this article demonstrates how the ACT framework can take a clinical teacher from an instinctive reaction—frustration with a particular student and the instinct to question that student to unpack the behaviors she is seeing—to an intentional teaching choice to create working models for a student team to maximize their thinking and communication styles. She also creates supervision exercises to broaden the students' thinking, and classroom sessions to build skills. It is our hope that this article will spur clinical teachers to use the ACT model to create bodies of knowledge for themselves and their colleagues, to use this knowledge to challenge their teaching instincts through the ACT method, to use this method to intentionally maximize learning for clinic students, and, ultimately, to achieve their goals.

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APPENDIX A

Adaptive Clinical Teaching (ACT) Method – Overview Chart					
A rticulate Situation <i>Describe the situation or challenge</i>	D efine Expectations <i>Identify and describe the outcome or clinic goal to be achieved</i>	A nalyze Factors <i>Identify and describe possible causes, influences, contributing factors, and contexts</i>	P onder Strategies <i>Identify potential courses of action</i>	T ake Action <i>Choose the strategy to implement</i>	S hape Strategies <i>Evaluate the outcome of the strategy and reflect on future choices</i>
Productivity Cognition Self-reflection Communication Relationships Emotions Role Values and Ethics Difference	Capacity for Future Learning Professional Values Skill Development Client Service Process	The Clinical Teacher The Clinic The Client The Student	Supervision Classroom Teaching Clinic Structure and Operation Student Role Do Nothing		Revise the chosen strategy Change strategies Add a strategy Use the ACT steps again

